NOTICE OF DEATH FORM

Within 4 hours of the discovery of a death that is or may be a Suspicious, Unexpected, or Unexplained Death, the entity responsible for reporting the death shall report it to the DIDD Investigator. Also, **within 4 hours** of the discovery of any death, the primary provider must notify the DIDD Regional Director or, if applicable, the DIDD Commissioner or designee by telephone. A completed **Notice of Death Form** must be sent **within 1 business day** after discovery of the death. If a waiver provider or private ICF/ID, send it to the DIDD Regional Director. If an ICF/ID, send it to the DIDD Commissioner or designee.

East DIDD Regional Director		**Middle DIDD Regional Director**		**West DIDD Regional Director**	
Phone #	(865) 588-0508	Phone #	(615) 231-5436	Phone #	(901) 745-7361
Fax #	(865) 594-5180	Fax #	(615) 231-5150	Fax #	(901) 745-7251
Crisis Pager	(855) 828-4717	Crisis Pager	(615) 963-1700	Crisis Pager	1-866-925-4204

PERSON SUPPORTED INFORMATION **DIDD REGION** [ ] East [ ] Middle [ ] West

NAME _____ **DATE OF BIRTH** _____

SOCIAL SECURITY NO. _____ **AGE AT DEATH** _____

RACE [ ] White [ ] Black [ ] Hispanic [ ] Other _____ **SEX** [ ] Male [ ] Female

CLASS MEMBER STATUS [ ] Settlement Agreement [ ] Remedial Order [ ] Not applicable

FUNDING STATUS [ ] "Statewide" Waiver [ ] "Self-Determination" Waiver [ ] Private ICF/ID
[ ] "Arlington" Waiver [ ] State-Funded [ ] Developmental Center

RESIDENCE
[ ] Lived with family [ ] Supportive Living [ ] Private ICF/ID
[ ] Lived in Own Home with Support [ ] Residential Habilitation [ ] Developmental Center
[ ] Lived Independently [ ] Medical Residential Services [ ] Nursing Facility
[ ] Family Model Residential Services [ ] Other (explain)_____

DID THE SERVICE RECIPIENT MOVE IN THE PAST 6 MONTHS? [ ] No [ ] Yes (specify date: _____)

DATE OF DEATH _____ **DATE REPORTED** _____ **TIME REPORTED** _____ AM / PM

PLACE OF DEATH [ ] Home [ ] Psychiatric Facility
[ ] Hospital [ ] Other _____

DETAILS OF DEATH _____

_____

_____

1. **AUTOPSY REQUESTED?** [ ] No [ ] Yes If so, by whom _____
2. **MEDICAL EXAMINER CONTACTED?** [ ] No [ ] Yes If so, by whom _____
3. **CORONER CONTACTED?** [ ] No [ ] Yes If so, by whom _____
4. **INCIDENT FORM SUBMITTED?** [ ] No [ ] Yes

INDICATE WHO HAS BEEN NOTIFIED [ ] ISC/Case Manager [ ] Legal Representative [ ] Family
[ ] DIDD Investigator [ ] Police

NAME OF PRIMARY CARE PROVIDER _____ **PHONE NO.** _____

TYPE OF CASE MANAGER [ ] ISC [ ] State Case Manager [ ] QMRP

NAME OF CASE MANAGER _____ **PHONE NO.** _____

NAME OF ISC AGENCY (if applicable) _____ **PHONE NO.** _____

NAME(S) OF NEXT OF KIN and/or LEGAL REPRESENTATIVE_____

GENERAL HEALTHCARE INFORMATION

NAME OF PERSON SUPPORTED

_____

AMBULATION: [ ] Ambulatory [ ] Non-ambulatory

COMMUNICATION [ ] Verbal [ ] Non-verbal

NUTRITION [ ] Eats independently [ ] Eats with assistance [ ] Tube-fed

WEIGHT IS [ ] Normal Weight [ ] Overweight [ ] Underweight

WEIGHT _____

HEIGHT _____

PHYSICAL STATUS REVIEW (if applicable) **DATE OF LAST PSR** _____ **PSR LEVEL** _____

MEDICATIONS

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ID LEVEL [ ] Mild [ ] Moderate [ ] Severe [ ] Profound [ ] Unknown/Unspecified

Etiology (if known) _____

BEHAVIORAL/PSYCHIATRIC DIAGNOSES

_____ _____

GENERAL MEDICAL DIAGNOSES

_____ _____

_____ _____

_____ _____

HOSPITALIZATIONS AND PROCEDURES IN PAST 12 MONTHS

Reason for Hospitalization or Procedure	Treatment Location	Date

_____ _____

Name of Provider, Private ICF/ID, or DIDD ICF/ID **Phone Number**

_____ _____

Print Name of Person Completing This Form **Title**

_____ _____

Signature **Date**